UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
WESTERN DIVISION

KIMENE M. JOHNSON, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	No. C02-4113-MWB **REPORT AND RECOMMENDATION**

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I. INTRODUCTION

The plaintiff Kimene Johnson ("Johnson") appeals a decision by an administrative law judge ("ALJ") denying her Title II disability insurance ("DI") benefits. Johnson argues the Record does not contain substantial evidence to support the ALJ's decision. (*See* Doc. No. 9)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On May 17, 2001, Johnson filed an application for DI benefits, alleging a disability onset date of September 15, 2000. (R. 91-93) The application was denied initially on September 14, 2001 (R. 70, 72-76), and on reconsideration on December 12, 2001 (R. 71, 79-82). On December 21, 2001, Johnson requested a hearing (R. 83), and a hearing was held before ALJ Robert Maxwell on July 24, 2002, in Spencer, Iowa. (R. 28-69) Johnson was represented at the hearing by attorney William C. Kurt. Johnson and her husband, Perry Johnson, testified at the hearing, as did Vocational Expert ("VE") Tom Audet.

On August 15, 2002, the ALJ ruled Johnson was not entitled to benefits. (R. 10-23) Johnson requested review of the ALJ's decision. The Appeals Council of the Social Security Administration considered additional evidence submitted by Johnson subsequent to the ALJ hearing (R. 7, 246-48), and on October 18, 2002, the Appeals Council denied Johnson's request for review (R. 5-7), making the ALJ's decision the final decision of the Commissioner.

Johnson filed a timely Complaint in this court on December 2, 2002, seeking judicial review of the ALJ's ruling. (Doc. No. 1) In accordance with Administrative Order #1447, dated September 20, 1999, this matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a

report and recommended disposition of Johnson's claim. Johnson filed a brief supporting her claim on May 30, 2003. (Doc. No. 9) The Commissioner filed a responsive brief on July 15, 2003. (Doc. No. 12). Johnson filed a reply brief on July 28, 2003. (Doc. No. 13)

Concurrently with her reply brief, Johnson filed a motion and supporting brief for remand of this matter pursuant to sentence six of 42 U.S.C. § 405(g) (Doc. Nos. 14 & 15), claiming she has "new and material evidence not available at the time of [the ALJ] hearing." (Doc. No. 14, ¶ 5) She states she filed an application for disability subsequent to the application at issue here, and has been found to be disabled. (*Id.*) Johnson continues to seek reversal of the Commissioner's decision on the application at issue here, but in the event the court "is unable to reverse the Commissioner's decision based upon the existing record," then Johnson seeks remand for the taking of additional evidence. (*Id.*, ¶ 4) On August 5, 2003, the Commissioner filed a resistance to Johnson's motion for remand (Doc. No. 16), in which the Commissioner also incorporated a response to Johnson's reply brief.

The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Johnson's claim for benefits and her motion for remand.

B. Factual Background

1. Introductory facts and Johnson's daily activities

a. Johnson's testimony

At the time of the hearing, Johnson was 48 years old, 5'7" tall, and weighed 230 pounds. (R. 31, 50) She and her husband were living in Auburn, Iowa, where they had lived for about a year. She stated that previously, they lived in Lake View, Iowa, for two years, and prior to that, in Arizona, for 17 years. (R. 31, 36) Johnson stated her husband

works for a fiberglass manufacturing company in Lake City, and his hours are from 7:00 a.m. to 4:30 p.m. (R. 36-37)

Johnson stated she starting working as a mail carrier in 1984, and worked in that capacity for 17 years in Tempe, Arizona. In early 2000, she transferred to Lake City, Iowa, where she worked part-time as a mail carrier from April to September of 2000. Her hours in the part-time job were from 6:45 a.m. until about 12:30 p.m., Mondays and Saturdays. (R. 32) Johnson explained she was having medical problems in Tempe, where she was working forty hours per week. She was sick frequently and had used up all but 120 hours of her sick leave. (R. 32-33) She stated the amount of sick leave she used up began increasing seven to nine years before she left Arizona, and increased as time went on. (R. 33-34) Johnson stated she was having problems with extreme exhaustion, fatigue, and flu-like symptoms. She originally was diagnosed with Epstein-Barr virus[1], one of the symptoms of which is fibromyalgia.[2] (R. 34) Johnson chose to transfer to Iowa because she and her husband both were from Iowa originally. (R. 47)

Johnson stated that before she became ill, she was very active. She did "a lot of camping and fishing and . . . had gotten several awards through the post office, recognition awards, carrier of the month." (R. 35) She walked ten to twelve miles per day on the job until the last two years in Arizona, when she had an apartment route, which did not require as much walking. She stated her job caused her to feel like her legs had "20-pound weights on them." (*Id.*)

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[1]Epstein-Barr virus is "a herpes-like virus that causes infectious mononucleosis and is associated with Burkitt's lymphoma and nasopharyngeal carcinoma." *Dorland's Pocket Medical Dictionary*, 736 (23d ed. 1982).

[2]Johnson later noted her original diagnosis was Epstein-Barr virus and "Valley Fever." (R. 51)

Johnson explained she quit the part-time job in Lake City in September 2000, because she had difficulty walking and was "just extremely exhausted." (R. 36) She explained that "[e]verything just seemed to take longer," and she felt like she was "taking two steps forward and one back . . . it just becomes so difficult and so extremely exhausting." (*Id.*) At the time she quit, her job was still in good standing and she did not have any personnel actions pending against her. (R. 46) She stated she currently was seeing Zoltan L. Pek, M.D. and Kaye Blessington, a physician's assistant. (R. 37; *see* R. 3, 238, for spelling of names) She stated her condition had not improved since she quit her job. (R. 37)

Johnson described her typical day. She stated she gets up between 5:00 a.m. and 8:00 a.m., depending on when she goes to bed or falls asleep. She does not sleep well, and she takes Trazodone, progesterone, and Excedrin PM to help her sleep. (R. 37-38) She stated the first thing she does when she gets up is pray. After that, she sometimes cries because she is in pain. She stated the pain is "everywhere," explaining, "It's just there. It's like being hit with the – it's like the day after somebody beat you up with a baseball bat. That's how you feel all over. And I can't show it, but it's there." (R. 38)

Johnson stated sometimes she does not get dressed at all. When she does dress, she can dress herself, but occasionally her husband helps her. She does not eat breakfast. Between 11:00 a.m. and 12:00 p.m., she usually microwaves leftovers from the previous evening's dinner, which her husband fixed. After eating, she will play or pet the cat, watch television, or sometimes read. (R. 38-39) She stated if she sits for longer than thirty to forty-five minutes at a time, she will stiffen up. (R. 42-43) Johnson stated she usually washes the dishes from the previous evening, if they did not use paper plates. She stated washing the dishes can take her a half hour, and sometimes she will start, then rest for awhile, and then go back and finish. (R. 39-40)

Johnson testified she takes Flexeril to "make movement a little bit easier," but she was not taking the drug daily at the time of the hearing. (R. 40, 52) She stated she would take "a pill once a week or something like that." (R. 53) She was given 30 pills when she filled the prescription in early 2000, and she had never refilled the prescription. (R. 52-53) She stated she currently was taking "about 800 milligrams a day" of over-the-counter Ibuprofen for pain. (R. 40)

Johnson opined she "could probably walk five, ten minutes without stopping," and then she would have to rest for fifteen or twenty minutes. (*Id.*) She stated she could stand for half an hour and then would have to rest. (R. 40-41) She stated she uses "two hands to lift a jar of pickles," and she cannot lift much. (R. 41) Her husband does all the shopping, carries in the groceries, vacuums, and does all of the cooking. Johnson usually sorts the clothes, her husband washes them, and then Johnson folds them. (*Id.*) She stated it takes her twenty to thirty minutes to fold the clothes, and she takes breaks while she folds them. (R. 41-42)

Johnson stated it had been two years since she went camping; she went once the first year she moved to Iowa. She explained she was unable to do the normal hiking and fishing she used to do. (R. 42)

Johnson reported she visits her in-laws in Lake City about once every two months. She stated they live about thirty miles away. She believes she can drive a car about thirty miles, but her hands cramp up when she holds the steering wheel. (*Id.*)

Johnson explained her treating medical practitioners have recommended certain exercises for her. She can do part of the exercises, but she will not get down on the floor to do exercises because she has "a really hard time getting up." (R. 43) She stated she had gained about eighty pounds during the year preceding the hearing. (*Id.*) Johnson stated she has pain when she gets up in the morning and has pain all the time, noting, "It's

always there. It never goes away." (*Id.*) During the hearing, she explained she had pain "everywhere," including her arms, legs, hands, neck, and shoulders. (*Id.*)

Johnson described her employment prior to working as a mail carrier. She stated she cared for handicapped children for awhile, which required her to lift the children. She did not believe she could perform that job now. She also worked in a factory once. She stated she has a high school degree, she attended college for a year-and-a-half, and she took some courses in about 1982, "at Fort Dodge for Mental Health Technician and Mental Health Worker." (R. 44) She did not believe she would be able to attend school, noting, "Just getting dressed can be a chore. Just getting dressed, combing my hair, it exhausts – it's exhausting. I just can't imagine. I'd have to get dressed, I'd have to comb my hair. I'd have to walk to the car. I'd have to drive." (R. 45)

Johnson stated her memory is "not as good as it used to be," and she sometimes forgets simple words. (*Id.*) Her doctors have not given her any hope that her condition will improve, telling her she will just have to deal with it. (*Id.*)

According to Johnson, she could not file for disability through the Postal Service because her condition was not caused by her job. She stated she was not receiving any type of retirement because her combined age and years of service would not qualify her for retirement benefits. She would have had to work eleven more years before she could draw retirement from the Postal Service. (R. 47)

In response to the ALJ's questioning, Johnson explained she saw Andre Abbate, M.D. while she was living in Arizona. After Dr. Abbate closed his practice in 1997, Johnson began seeing Lloyd Brenden, M.D. She stated there was a period of time after she returned to Iowa when she did not see a doctor. She explained she had started the part-time job and thought she would get better. (R. 49)

Johnson stated she smokes a pack of cigarettes or less per day, and she is "trying to cut down." (R. 49-50) She stated her doctors want her to exercise or walk for brief periods several times a day, but she was unable to state any particular restrictions any doctor has imposed on her due to her condition. (R. 50-51)

Johnson stated she reads best sellers, and articles on fibromyalgia. She does not have trouble understanding what she reads. She opined she usually reads for half an hour at a time. (R. 53) Johnson denied any history of emotional or mental problems, and she stated no medical practitioner has ever told her that her pain has an emotional or psychological cause, rather than a medical cause. (*Id.*) In fact, she stated "they almost say the opposite," explaining, "They understand why I get depressed, is because they understand that the pain is there, and that that is depressing." (R. 53-54)

The ALJ noted that in denying Johnson's application, Social Security Administration personnel had agreed Johnson was unable to continue working as a letter carrier, but thought she should be able to do sedentary work, primarily using her hands. Johnson stated she believes that conclusion was in error because she "struggle[s] just to get through the day," just being at home. (R. 54) She does not believe she could be at a job five days a week, eight hours a day. She stated she probably could work for one day, but then it would take her two or three days to recover. She has not looked for work since she left her part-time position as a letter carrier, although she stated her family's financial situation makes it important for her to earn income. (R. 54-55)

b. Perry Johnson's testimony

Perry Johnson ("Perry") stated he had been married to Johnson for 19 years, and he was present during Johnson's testimony. He agreed that he does most of the cooking, although Johnson occasionally will "microwave a pizza, or something like that." (R. 56)

Perry testified he and his wife used to enjoy camping, fishing, hiking, and going up into the mountains. He stated that in about 1995, Johnson started seeing a doctor about her medical problems. She had less energy and was not able to do some of the things she used to do. He explained that before Johnson became ill, she could hike for a mile, but now she can hardly walk 100 yards. After five minutes of walking, she is unable to keep going and has to stop and rest. (R. 57)

Perry stated he does most of the household chores and yard work, and he and his father take care of the garden. (R. 57-58) He does the grocery shopping, brings in the groceries, and puts them away. He stated Johnson would be able to pick up a gallon of milk and put it away, "if she had to," but she would be unable to put away all of the groceries. (R. 60)

Perry views Johnson as someone who "used to be able to work, take care of the household and do recreational things," but now "basically just tries to get through, day by day." (R. 58) Perry stated he is employed full time. (R. 61) He gets up at 5:00 a.m. and leaves the house around 6:00 a.m., and Johnson is not out of bed when he leaves. He stated Johnson is able to dress herself for the most part, but he helps occasionally with "things it's hard for her to reach." (R. 59)

Perry stated he sees evidence of Johnson's pain on a daily basis, and the pain affects Johnson's ability to move and accomplish simple tasks. (R. 59) He sees Johnson crying quite often, which she did not do previously. He does not believe Johnson could maintain either full-time or part-time work, stating, "When she did work, she did a good job. She was very good at what she did. That's the type of person that she is. She gave it her all, but I think right now, it would just be too difficult, and I think she could probably do the job for a day, but I think there would be trouble for days to come." (R. 60) He does not believe she could perform repetitive arm movements, or bend, stoop and lift continually

for any length of time. (R. 61) He opined she could not sit for more than an hour at a time because, in his opinion, she would be in pain and would have to get up and change positions. (R. 59)

2. Johnson's medical history

On July 20, 1995, Johnson saw Andre V. Abbate, M.D., complaining of muscle fatigue, overall fatigue, and joint pain for two weeks. Johnson reported the condition was affecting her work as a mail carrier. She had been seen at an urgent care clinic, where she was given Erythromycin and Motrin, and was told to follow up with a local doctor. (R. 189) Johnson had a positive skin test for Valley Fever, but subsequent laboratory blood testing was negative. (R. 185-86; *see* R. 180) Due to the positive skin test, the doctor noted Johnson should be rechecked in six weeks. (R. 185) Dr. Abbate ordered a chest X-ray, which showed a small, vague nodule of undetermined etiology in Johnson's right upper lung. (R. 189-90)

A mammogram was performed on July 24, 1995, that indicated no obvious tumors, but two areas of suspicion in her right breast that the doctor speculated were fibrocystic disease. A follow-up mammogram was recommended in six months. (R. 188) The same day, Johnson also underwent a CT scan of her chest. The CT scan clarified the vague nodule that had been identified in the chest X-ray, identifying it as a calcified nodule "presumably representing a calcified granuloma." The doctor recommended a recheck in three months. (R. 187)

On August 10, 1995, Dr. Abbate wrote Johnson a work release for the period from August 7-13, 1995, due to "recurrent symptoms related to lung nodule." (R. 182) Dr. Abbate ordered further laboratory tests, which revealed a very high Epstein-Barr Virus ("EBV") titer. The doctor prescribed B-12 shots to see if that would help Johnson's

malaise. (R. 181) He placed Johnson on restricted work duty ("desk duty only") until at least early September, when she was scheduled for a follow-up evaluation. (R. 180)

On August 21, 1996, Johnson called Dr. Abbate and reported she was unable to function at work and she was tired. He recommended she go on light work duty, and he gave her some literature on EBV. He wrote a letter to Johnson's employer dated August 25, 1995, in which he clarified that Johnson had been presumptively diagnosed with Valley Fever due to the positive skin test, and her positive EBV titer indicated the possibility of "a concomitant viral illness." (R. 178) He planned to repeat the lab tests to confirm the diagnosis. In the letter, the doctor noted Johnson was having "associated problems of fatigue[], malaise, and diffuse arthralgia and myalgia," and he recommended non-steroidal anti-inflammatory drugs, and possible weekly injections of vitamin B-12. He suggested Johnson go on desk duty for at least two to three months, and "avoid extensive walking and/or lifting." (*Id.*)

Johnson returned for a follow-up exam on September 6, 1995. Dr. Abbate noted Johnson was not as tired and fatigued as before. He noted she had "been reading the book on Epstein-Barr virus and chronic fatigue[], and seem[ed] to understand it." (R. 172) A skin rash on Johnson's left anterior chest had resolved. Dr. Abbate talked with Johnson about giving herself weekly B-12 injections. They also talked about a drug called Gammar, which the doctor stated would not be available until 1996. He planned to let Johnson "try to go back to work at her own pace," if her supervisor would allow it, and told her to return in one month for further follow-up. (*Id.*) Dr. Abbate listed Johnson's diagnoses as Epstein-Barr virus, lung nodule, malaise, rule out Valley Fever, and resolved skin rash. (*Id.*)

At the September 6, 1995, exam, Dr. Abbate completed a form for Johnson's employer indicating that based on Johnson's ability to sustain activity at that point in time,

she could lift/carry five pounds continuously and ten to fifteen pounds intermittently for a total of four hours per day; sit for a total of four hours per day; and, during an eight-hour workday, stand for one hour continuously and up to four hours intermittently; walk for thirty minutes continuously and up to two hours intermittently; climb up to four hours intermittently; kneel for one to two hours intermittently; and bend, stoop, twist, pull, and push for up to two hours intermittently. He stated she would have no problems with the following on a continuous basis during an eight-hour workday: simple grasping, fine manipulation, reaching above her shoulders, driving a vehicle, operating machinery; or being exposed to temperature extremes, high humidity, chemicals and solvents, dust and fumes, and noise. (R. 175) Dr. Abbate noted Johnson's condition "may or may not improve," and he suggested "slow introduction of activity." (*Id.*) On the form, the doctor listed Johnson's diagnoses as lung nodules, Valley Fever, and EBV. (*Id.*)

Johnson returned to see Dr. Abbate on October 5, 1995, for follow-up. She stated she had noted some improvement over the last week. She was back to working as a mail carrier, and she was giving herself B-12 injections. She stated she still had "aches and pains, myalgias and arthralgias," and the rash under her left breast would come and go. The doctor told Johnson to continue with the B-12 shots and continue working at her regular job. She was instructed to return for follow-up in three months, and the doctor planned to repeat the EBV titer in six months. (R. 170)

Johnson had a repeat mammogram on December 21, 1995. The test continued to reveal some suspicious areas in her right breast, and she was referred to another doctor for follow-up. (R. 168) The doctor noted some thickening in Johnson's breasts, but "no distinct or dominant mass." (R. 167) He diagnosed "[f]ibrocystic disease with thickening in the upper outer quadrant of both breasts, more marked on the right," and no evidence

of malignancy or need for biopsy. He recommended Johnson have a yearly mammogram and do monthly self-examinations, and seek follow-up for any palpable masses. (*Id.*)

Johnson returned to see Dr. Abbate on January 24, 1996. She reported improvement on the B-12 injections, and she was feeling less fatigued. She still reported a lot of arthralgias and myalgias, but she was able to perform her job as a letter carrier. She stated she had switched her routes and was delivering to four large apartment buildings, which required less walking. The doctor suggested increasing the B-12 to 1,000 mg. twice a week for one month. He talked to Johnson about the possibility of even higher doses of B-12, noting, "This is always a controversial issue using vitamin B-12 for the EBV/chronic fatigue syndrome, but it does seem to help and she has had improvement on a smaller dose." (R. 166, 170) Johnson was instructed to follow up in six months.

Johnson saw Dr. Abbate again a year later, on January 31, 1997. He noted she had gained twenty-four pounds since her last visit. She reported walking less on her job, and stated she "tried exercising on a treadmill, but had to burn a tremendous amount of calories and unfortunately did not los[e] all the weight she expected." (*Id.*) She complained of upper respiratory symptoms with nasal congestion and thickish, white-grey drainage. Dr. Abbate diagnosed her with acute sinusitis, mild pharyngitis, weight gain, obesity based on her body size and height, and EBV. He told her to continue the B-12 injections, and he prescribed Aerotab for ten days, and Vancenase AQ spray and Ocean spray "to help wash out the secretions." (*Id.*) He instructed Johnson to cut her calories down to 1200 or less per day and increase her activity. She was scheduled for follow-up in four months. (*Id.*) The doctor refilled Johnson's prescription for syringes for the B-12 injections in April and May 1997 (R. 164-65), but the Record does not contain further notes from office visits with Dr. Abbate.

It appears, however, that Johnson did see Dr. Abbate again, because he referred her to Lloyd D. Brenden, M.D. in August 1998, for biopsy of "a changing pigmented lesion on the right upper and lateral forehead at the hairline," as well as a "pigmented lesion on the right cheek." (R. 192) Dr. Brenden performed a biopsy of the forehead lesion on August 18, 1998, and diagnosed "an inflamed and irritated junctional nevus" (*i.e.*, skin malformation) requiring no further treatment. He assured her the lesion on her right cheek was benign. (R. 191-92)

Johnson saw Scott Rigden, M.D., in January 1999, complaining of a bad cold and runny nose, and a cough since January 3, 1999. (R. 219, 195) On her intake medical history form, Johnson indicated she had significant difficulty with her energy level. (R. 220) A chest X-ray revealed the same granuloma noted in the prior X-rays, but no acute disease processes. The films also revealed some minimal degenerative spurring along her ventral thoracic spine. (R. 195) On January 27, 1999, Johnson completed extensive questionnaires provided by Dr. Rigden relating to her condition, including a Chronic Fatigue Syndrome Questionnaire (R. 208-18), Work-Related Activities Form (R. 206-07), Metabolic Screening Questionnaire (R. 203-04; *see* R. 201-02), Pain Assessment Survey (R. 198-99), and Cheney Clinic/Activity Schedule (Subjective Functional Capacity) (R. 200). She reported the onset of chronic fatigue syndrome in 1995, with gradually increasing muscle weakness, depression, pain, and trouble sleeping. (R. 197) She listed her worst pain areas as her joints, back, muscles, and hips/legs, in that order. (R. 198) She reported taking Tylenol PM and Motrin more than twice daily for pain, receiving "a little" relief from the medications. (R. 199)

Johnson reported having minimal difficulty with bathing, dressing, feeding, and caring for herself. She stated she did laundry regularly, without help; drove on distant trips or in traffic; and engaged in social activities once or twice per month. She indicated

she was unable to do much housekeeping, limited to light dusting and straightening up, and her husband did all the grocery shopping and cooking. (R. 200)

Johnson stated at that time she was able to lift twenty pounds occasionally and ten pounds frequently, noting she was required to lift seventy pounds and carry thirty-five pounds in her job. She stated she could stand and/or walk for about six hours in an eight-hour workday, noting she got a half hour for lunch and two ten-minute breaks during the day. She indicated her lunch period and breaks did not provide her with relief, and she determined what she was able to do "one step or one movement at a time." (R. 206) Johnson reported climbing and stooping frequently, and balancing, kneeling, crouching, and crawling occasionally. She stated she was unlimited in her ability to reach, handle, finger, feel, see, hear, and speak, and she had no environmental restrictions. (R. 207)

In reviewing her medical symptoms, Johnson reported suffering recurrent fever or subnormal temperature (not specified), prolonged fatigue after even minimal effort, muscle aches and pains, generalized muscle weakness, aching or pain in her joints, sleep disturbances, forgetfulness and memory problems, confusion or disorientation in familiar places, difficulty comprehending or concentrating, problems keeping up on a train of thought, trouble speaking or using words, and irritability or emotional lability. (R. 209) She further reported having night sweats, digestive problems, weight gain, shortness of breath on minimal exertion, chest fullness or pain, weakness in her arms and legs, dizziness or vertigo, staggering gait, anxiety or feeling of panic, dry eyes and/or mouth, and hair loss. (R. 210) She indicated she was still taking vitamin B-12 shots twice weekly. She reported smoking a pack-and-a-half a day, using alcohol infrequently, and drinking three caffeinated soft drinks a day. (R. 212)

Johnson described her illness as follows:

> I feel I push myself because it's not an illness that's visible. I look whimpy [sic]. I have a lot of muscle cramps in back, chest, sides, legs. My arms and legs feel like they are full of lead. I feel weak. If someone grabs my arm, I almost black out. It about drops me. I don't sleep well. If I take Tylenol PM, I will sleep 3 to 5 hrs. and wake up 3 to 10 times. I have a hard time falling asleep and staying asleep. Sometimes I function 1 minute at a time instead of 1 day at a time. Like I'll say to myself – OK, just take one more step or just brush your teeth and then you can stop. And that's how I deal with it. I want and need help. I need guidance and back-up. I would like to sleep, have energy, lose weight and stop smoking. Those are my goals but I have trouble believing I can accomplish these by myself. I barely function as I used to and I want that back.

(R. 215) On the Fatigue Questionnaire, Johnson indicated her fatigue is brought on by heat, stress, depression, and work, and her fatigue is worse in the morning. She indicated her motivation is lower when she is fatigued and she has trouble concentrating. Performing routine daily activities increases her fatigue, and resting provides little relief. (R. 216) She indicated fatigue interferes with her physical functioning, work, family, and social life. She stated her fatigue is different in quality or severity than it was before she developed the condition. (R. 216-17)

Dr. Rigden saw Johnson for follow-up on February 4, 1999. At that time, Johnson reported "severe throbbing pain in both legs" for two days, with no obvious triggering factor. She stated she got no relief from baths, massage, or Motrin. Her upper respiratory infection was somewhat better. The doctor ordered a Magnesium level and chest X-ray, and prescribed Tessalon Perles, Robitussin, and Theodur for the coughing and wheezing. (R. 194)

According to the Record, Johnson did not see a doctor again until April 2001, after she and her husband had moved back to Iowa. She was seen for an intake examination at

Community Physicians Associates in Lake City, Iowa, on April 6, 2001. She reported she had been "diagnosed with fibromyalgia, chronic fatigue, insomnia and . . . Epstein-Barr." (R. 225) She was not taking any prescription medications, but reported taking over-the-counter vitamins and minerals. Johnson reported smoking two-and-a-half to three packs of cigarettes daily. She stated "her joints, the bottoms of her feet and sometimes the inside of her skin hurts and burns," and she complained of "shoulder pain, back pain, hip pain, waist pain, knee pain, calf pain, and foot pain." (*Id.*) Physician's Assistant Pat Weishaar ordered a sed rate, RA, ANA, EBV titer, TSH, and several other laboratory tests, and instructed Johnson to return in one week. P.A. Weishaar also planned to request information from Johnson's previous caregivers. (*Id.*)

Johnson returned for follow-up on April 17, 2001. Of the many tests ordered, "the only thing that was abnormal was that she had a sed rate of 47." (R. 222) P.A. Weishaar noted the elevated sed rate indicated a positive for EBV, and gave Johnson an injection of Kenalog and started her on a cycle of "Doxycycline 100 mg. daily for 6 weeks and then off 2 weeks and then repeat this cycle again for up to a year." (*Id.*) Johnson was scheduled for follow-up in one month. P.A. Weishaar told Johnson that if the steroid injection helped, she could have another injection in three months. (*Id.*)

P.A. Weishaar saw Johnson again on May 14, 2001, "to get the results of her lab and try to come up with some kind of treatment for the fibromyalgia." (*Id.*) Johnson reported the Kenalog injection had not helped. The P.A. had given her Sonata to help her sleep, but Johnson stated that also had not helped. Johnson had lost five pounds and was down to 218. Her sed rate was still 47, and her EBV titer was elevated. P.A. Weishaar diagnosed her with sleep deprivation, fibromyalgia, hyperlipidemia, and positive EBV. The P.A. ordered a sleep study to rule out apnea, and started her on Celebrex for the pain. They discussed the possibility of antidepressant medications, but decided to wait until after

the sleep study. (R. 220-21) Johnson stated she was taking malic acid, which she thought helped her some. The P.A. instructed Johnson to return for follow-up after the sleep study was completed. (R. 221)

Johnson underwent a mental health examination by William E. Morton, Psy.D., at the request of the Iowa Department of Disability Determination Services on August 9, 2001. Johnson reported quitting her job in September 2000, due to "the physical discomfort she was experiencing due to the Epstein-Barr." (R. 232) She stated she enjoyed reading, and she was unable to engage in much physical activity because it would "tire her out." (*Id.*) Dr. Morton noted Johnson was "moderately overweight," dressed appropriately, and had appropriate hygiene. He noted Johnson "presented with normal posture, locomotion, and gait. . . . She evidenced no difficulty with extended sitting or arising from a seated position." (R. 232-33) She was alert, attentive, and cooperative during the interview.

Dr. Morton found Johnson to have depressive symptoms arising from "some serious medical problems." (R. 233) He noted she could "attend to the activities of daily living within the limits of her physical difficulties." (*Id.*) He found no evidence of any mental limitations that would affect her ability to function in or out of the workplace. He diagnosed Johnson with Adjustment Disorder with Depressed Mood, chronic, and assessed her current GAF at 70, indicating mild symptoms or some difficulty with social and occupational functioning. (*Id.; see* DSM-IV at 32)

Johnson underwent a disability physical examination by Zoltan L. Pek, M.D. on August 6, 2001. The doctor listed Johnson's current medications as Doxycycline, flax seed oil, calcium, malic acid, melatonin, and serotonin. (R. 237) Johnson reported being diagnosed with EBV in 1995, and "always having some type of pain" since that time. (R. 236) She stated she was unable to work because of pain "technically all over, in her

feet, shoulders, back, hip, waist, knees and heels. She is always hurting." (*Id.*) Johnson also reported having insomnia, waking several times during the night and never having a restful night of sleep. (*Id.*) She stated she would sleep for about five hours, waking about seven times during that period. (R. 237) She stated she had been a smoker for 32 years, and smoked two to two-and-a-half packs a day. She reported gaining about 80 pounds in the previous seven to eight years, and her current weight was 221 1/2 pounds. (R. 236)

Johnson described her current complaints as follows:

> She stated she is not able to do much at home; she mainly reads and watches TV. Most of the household work is taken care of by her husband. She gets tired very easily. She feels very stiff after sitting down and has trouble moving around. She mainly has trouble when she has to get down on the floor or if she has to kneel. She does complain of having frequent muscle cramps, mainly in the upper and lower extremities but occasionally in her back too.

(*Id.*)

In performing a fibromyalgia evaluation, Dr. Pek noted "positive control points" at Johnson's "bilateral volar (anterior) forearms," left and right; bilateral anterior thighs, left and right; and bilateral mid-tibia, left and right (R. 239), and he noted, "She seems to be tender in all spots possible." (R. 236) With regard to Johnson's extremities, the doctor noted, "She has a fairly good range of motion in the upper and lower extremities. No swelling. No cyanosis, edema or clubbing. She had mild swelling around the knees, especially on the left side, but [the doctor] was not able to palpate significant joint effusion. No calf tenderness. She does have very small varicose veins but no sign of inflammation." (*Id.*)

Dr. Pek diagnosed Johnson with fibromyalgia, chronic fatigue syndrome, EPV by history, chronic insomnia, and mild obesity. (*Id.*) He opined Johnson would be "unable

to lift or carry any significant weight or standing and walking that is required for a regular 8-hour work day." (*Id.*) He recommended she take Flexeril 10 mg. twice daily, and probably take a non-steroidal anti-inflammatory. He also recommended she see a rheumatologist. (*Id.*) He noted Johnson was going to follow up with her regular doctor.

On September 6, 2001, Dee E. Wright, Ph.D. performed a Psychiatric Review Technique of Johnson and found she did not manifest "severe limitations of function, cognitively, socially, or with activities of daily living from a psychological perspective." (R. 153) Dr. Wright found Johnson suffered from "a chronic Adjustment Disorder with Depressed Mood (mild)," which was not sufficiently severe to meet the Listing requirements. (*Id.*; *see* R. 139-53) Philip R. Laughlin, Ph.D. reviewed the record and affirmed Dr. Wright's findings on December 15, 2001. (R. 139)

On September 8, 2001, Stephen Elliott, D.O., Ph.D. completed a Physical Residual Functional Capacity Assessment of Johnson. (R. 154-63) He found Johnson could lift ten pounds occasionally and less than ten pounds frequently, stand and/or walk at least two hours in an eight-hour workday, and sit about six hours in an eight-hour workday, noting these limitations were due to her fibromyalgia and chronic fatigue. (R. 155) He found she would have occasional postural limitations and should never climb ladders, ropes, or scaffolds, but he found no other exertional or postural limitations. (R. 156-57) He also found she should avoid concentrated exposure to extreme cold, heat, wetness, humidity, and hazards. (R. 158) Dr. Elliott noted, "Dr. Pek gives significant limitations in [Johnson's] remaining abilities without any physical findings to adequately support these limitations. He states she is limited by fibromyalgia but 6/8 control trigger points were positive in her exam. He also states 'she seems to be tender in all spots possible.' This fact and statement would tend to invalidate limitations based on her stated history of

fibromyalgia." (R. 160) Dennis A. Weis, M.D. reviewed the Record on December 8, 2001, and affirmed Dr. Elliott's findings. (R. 154)

Johnson saw rheumatologist Dr. David Gerbracht on December 5, 2001, for consultation. He noted Johnson's only medication at that time was Doxycycline, which she had been on for three months "for a possible unexplained infection." (R. 243) Unfortunately, the Record is missing two pages from Dr. Gerbracht's treatment records. It appears only the front sides of the two-sided pages were copied and made a part of the Record. Therefore, the Record does not contain his examination findings from December 5, 2001. The notes from that date resume in the middle of his treatment recommendations, with recommendation number 5, and continuing as follows:

> 5) She is to discontinue the doxycycline. 6) She will have a repeat sedimentation rate, and we will correlate that with a C-reactive protein and serum protein electrophoresis. 7) She will be seen in follow-up in eight weeks. 8) If her sleep does not improve, I have spoken to Doctor Spencer who will see her in Lake City regarding the possibility of using nasal CPAP. Disturbed sleep is definitely a modulator for pain.

(R. 242) When Johnson saw Dr. Gerbracht for follow-up on February 5, 2002, the records again are incomplete. He noted the Trazodone was helping Johnson sleep better, and she was getting six to eight hours of undisturbed sleep. He noted she still had diffuse aching and stiffness, but she was "free of any symptoms suggestive for a systemic connective tissue disease, seronegative spondyloarthropathy, or reactive arthritis." (*Id.*) He indicated Johnson's sed rate at her prior visit was elevated, which "would go along with the mildly increased $alpha_1/alpha_2$ globulins that she has." (*Id.*) He opined the elevated sed rate and increased alpha globulins were "probably idiopathic," and her prior blood chemistry profiles and blood counts were unremarkable. (*Id.*)

Upon examination, Dr. Gerbracht found Johnson to have no muscle atrophy or motor weakness, and "full painless range of motion of her peripheral and axial joints." (*Id.*) He noted she continued to have "diffuse tender points in her lateral elbows, upper trapezius trunk, interscapular area, lower lumbar paravertebral musculature, lateral aspect of her hips, and inferomedial aspect of her knees." (*Id.*) The doctor diagnosed Johnson with diffuse fibromyalgia, sleep apnea, and mildly elevated sed rate due to mildly increased $alpha_1/alpha_2$ globulins. (*Id.*) Further notes regarding his diagnoses and treatment recommendations are missing from the Record.

Dr. Pek saw Johnson again on January 2, 2002. She complained of feeling "very depressed," indicating she was unable to do much because of her fibromyalgia, and stating she had been "hurting all over." (R. 235) Johnson stated the Trazodone prescribed by Dr. Gerbracht was helping her insomnia. She reported experiencing significant mood swings, being very emotional, and feeling very depressed about her situation. The doctor noted Johnson "used to be quite an active person, but she has not been able to do much for the last few years. She even had to quit her job." (*Id.*) On examination, the doctor noted no significant swelling in Johnson's extremities, and no calf tenderness. He noted she appeared "very sad," and was "tearful during the whole visit and sometimes crie[d]." (*Id.*) Dr. Pek recommended she continue the Trazodone at night. He prescribed Remeron, and gave her enough for one month, and he opined she likely needed hormone replacement therapy. He instructed Johnson to return or call for follow-up, especially if her symptoms did not improve, and he planned to start her on an anti-depressant before initiating any hormone replacement therapy. (R. 234-35)

Johnson was seen in Dr. Pek's office on May 15, 2002, for follow-up of fibromyalgia and hormone replacement therapy. Office notes indicate she had been on hormone replacement therapy since January; however, there are no intervening notes between

January 2 and May 15, 2002, to indicate when the therapy was started. The doctor noted Johnson "has significant problems with fibromyalgia, to the point that she can hardly finish one task per day without severe pain and fatigue. She feels a little better with the hormone replacement therapy. She can at least do more than one thing without becoming extremely exhausted." (R. 245) The doctor continued Johnson's current hormone dosage pending the results of a Saliva Test. He noted incidentally that Johnson was "currently seeking disability benefits," and he opined she was entitled to benefits "due to her significant fibromyalgia problems." (*Id.*)

Johnson saw Dr. Pek again on August 21, 2002. He noted she was "feeling very exhausted" and had "significant pain in her extremities, back and neck with any kind of exertion." (R. 246) Johnson reported she had not been able to do much at home. She said taking a shower felt good, but it made her very exhausted. She stated the Trazodone was helping her sleep, but she still awakened frequently during the night, and even with eight to ten hours of sleep, she still felt very fatigued when she woke up. She reported the hormones did not help her chronic pain, and she felt stiff and hardly able to move. The doctor noted Johnson's weight was stable, and she weighed 221 pounds at the time of the examination. She stated she was taking the Trazodone and hormones, and she took Excedrin PM every night. (*Id.*)

Upon examination, Dr. Pek found Johnson to have "very mild swelling around her knees." He checked trigger points on her neck, back, anterior chest, arms, and legs, and noted she was "tender all over." Her sed rate remained elevated. His diagnoses were "Fibromyalgia, quite severe. Chronic insomnia. Hormone replacement therapy. Increased BMI (body mass index). History of Epstein-Barr virus infection. History of chronic fatigue syndrome." (*Id.*) Dr. Pek prescribed Bextra, noting, "Hopefully this will give her some relief so that she is able to function at least at home. I still do not believe

she will be able to find a job which she could do in her present condition." (*Id.*) He scheduled a follow-up exam in two weeks. (*Id.*)

Dr. Pek saw Johnson again on September 4, 2002. His notes are ambiguous, indicating the Bextra "helped her symptoms, but she does not feel any better. She could not really tell the difference after going on the medication." (R. 247) Her sed rate was still elevated, and she was still feeling exhausted and was not sleeping well. She reported the same symptoms as before, again making it curious that he noted the Bextra had "helped her symptoms." The doctor directed Johnson to continue taking her current medications, and he prescribed prednisone and scheduled a recheck of Johnson's sed rate in four weeks. (*Id.*)

3. Vocational expert's testimony

VE Tom Audet testified Johnson "would have transferable skills down to post office clerk, which is a light duty semi-skilled job, and the other jobs, like mail handler, which is a light duty job, and mail clerk, are unskilled jobs, so she really wouldn't need the transferable skills." (R. 64) Considering someone under age 50, who has a high school education and a little college, Johnson's work history as a semi-skilled mail carrier, and the work-related limitations Johnson described in her testimony, the VE opined the individual would not be able to return to Johnson's past work due to her physical limitations, and would not be able to do any other type of full-time work on a consistent basis. (R. 64-65)

The ALJ then asked the VE to assume a person of the same age, and with the same education and work experience, with the following residual functional capacity (which the ALJ stated was taken from the RFC evaluation performed by Dennis A. Weis, M.D., *see* R. 154-63):

> [T]he person could occasionally lift or carry ten pounds, frequently less than ten pounds, stand, walk with normal breaks at least two hours of an eight-hour day, sitting with normal breaks about six hours a day. Push-pull is unlimited, postural activities are all occasional except never climbing of ladders, ropes or scaffolds. No manipulative, visual, communicative limitations[;] from an environmental stand-point, avoid concentrated exposures to extremes of cold, heat, wetness, humidity and hazardous working conditions.

(R. 65-66) The VE stated the hypothetical individual still would not be able to return to her past work, but would be qualified for "a number of unskilled and entry-level types of positions," citing night auditor in a motel, assembly-type positions such as jewelry assembler, and surveillance systems monitor. (R. 66) Again, however, if the Johnsons' testimony were given full weight and credit, the VE stated the individual would be unable to perform any occupation. (R. 57)

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *see Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, "one that significantly limits the claimant's physical or mental ability to perform basic work activities." *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant's impairments and vocational factors such as age, education and work experience. *Id.*; *accord Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)).

Step five requires that the Commissioner bear the burden on two particular matters:

> In our circuit it is well settled law that once a claimant demonstrates that he or she is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first

> that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O'Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

Nevland v. Apfel, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added); *accord Weiler v. Apfel*, 179 F.3d 1107, 1110 (8th Cir. 1999) (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

B. The Substantial Evidence Standard

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Weiler, supra,* 179 F.3d at 1109 (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley, supra,* 133 F.3d at 587 (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the

Commissioner's conclusion." *Krogmeier, id.*; *Weiler, id.*; *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier,* 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell, id.; Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does "not reweigh the evidence or review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *see Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939

(8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier,* 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997); *accord Pearsall,* 274 F.3d at 1217; *Gowell, supra*.

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.,* 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.,* 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.,* 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala,* 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan,* 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;
> 4) dosage, effectiveness and side effects of medication;

5) functional restrictions.

Polaski, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

IV. ANALYSIS OF ALJ'S DECISION

The ALJ found Johnson had not engaged in substantial gainful activity since her alleged disability onset date of September 15, 2000. (R. 14; R. 21, ¶ 2) He found Johnson's fibromyalgia to be a severe impairment, and her chronic adjustment disorder with depressed mood to be an impairment that is "not severe."[3] He further found Johnson's fibromyalgia did not meet or equal the level of severity required by the Listings. (R. 19; R. 21, ¶ 3) The ALJ found Johnson to have "the functional capacity to perform work activity at the sedentary exertional level," except she would be limited to standing or walking for less than two hours in an eight-hour workday, and she could only perform postural activities on an occasional basis. In addition, he found she would have to avoid temperature and humidity extremes, and she could not work at heights or around dangerous machinery. (R. 20; R. 22, ¶ 5) He found that although Johnson would be unable to return to her past work as a mail carrier, she could perform jobs as a night auditor, jewelry assembler, surveillance monitor, and electronics assembler, all of which exist in sufficient numbers in the regional economy. (R. 20; R. 22, ¶ 12) As a result of these findings, the ALJ concluded Johnson was not disabled at any time through the date of his decision, and he denied her application for disability benefits. ((R. 22, ¶ 13)

In reaching these conclusions, the ALJ focused heavily on his determination regarding Johnson's credibility. His decision to discount medical evidence of record was

[3]The ALJ failed to address Johnson's diagnosis of chronic fatigue syndrome.

based on the fact that Johnson's doctors relied on her subjective pain complaints in reaching their diagnoses. The court will examine the ALJ's opinion in further detail to determine whether substantial evidence exists in the Record to support his conclusions.

The ALJ found Johnson's testimony regarding her experience of pain to be consistent with her statements to medical professionals and in procedural documents. However, he further found her "[t]estimony and statements in record . . . as to the degree of pain and functional limitation she experiences were exaggerated, not fully credible, and not substantially supported by medical evidence and opinion in record considered in its entirety." (R. 14, 19) Despite Johnson's contention that she experiences daily, disabling pain, the ALJ found it noteworthy that the medical professionals who examined Johnson did not observe her to be in any "acute distress" or to exhibit "any degree of pain or functional limitation" during the course of their examinations. (R. 18-19) The ALJ noted Johnson nevertheless "consistently assert[ed] she experienced pain throughout her body and related tender spots in virtually every point examined by various medical professionals." (R. 18)

The court finds the Record does not support the ALJ's credibility determination. Although Johnson's doctors noted she appeared to have full range of motion, every doctor she has seen since 1995 has consistently noted her ongoing complaints of pain. Johnson's report that she is in constant pain is not inconsistent with a failure to exhibit acute distress at the time of examination.

Furthermore, the ALJ failed to consider Johnson's substantial work history in assessing her credibility. The Record indicates Johnson worked full time for sixteen years and had an excellent work record, even receiving awards from her employer. When she no longer felt able to work full time, she made an effort to work part time, only quitting when she felt she could no longer function in the job. In a Daily Activities Questionnaire

completed by Johnson at the time of her application for benefits, she described herself as a hard-working, efficient employee, who got along well with her supervisors and coworkers. (R. 123) She expressed a desire to have her career back and to be strong and independent again. She stated she wished she did not have to apply for benefits or fill out the paperwork, and she wished the Social Security Administration had "never heard of [her]." (R. 124) Perry Johnson's testimony corroborates Johnson's assertion that she was a hard worker who was good at her job.

In short, there is no evidence anywhere in the Record that Johnson was malingering. As the ALJ noted, Johnson was consistent in her statements to medical practitioners, in procedural documents, and in her testimony. The ALJ failed to give proper weight to the consistency of the Record and to Johnson's work history. As the Eighth Circuit Court of Appeals held in *Nunn v. Heckler*, 732 F.2d 645, 648 (8th Cir. 1984), "'A claimant with a good work record is entitled to substantial credibility when claiming an inability to work because of a disability.'" *Id.* (quoting *Rivera v. Schweiker*, 717 F.2d 719, 725 (2d Cir. 1983)).

The ALJ also noted "a significant gap" in Johnson's medical treatment between February 1999 and April 2001, and found no evidence that she had taken "any prescription pain or anti-inflammatory medications during the relevant time period at issue . . . for treatment of her reported severe and constant pain." (R. 17) The ALJ found both of these facts to be "quite surprising and not supportive of [Johnson's] credibility in regard to her assertions of pain and fatigue." (*Id.*) Johnson's failure to seek frequent medical attention and try different medications is understandable under these circumstances. Johnson noted she had tried and taken different medications, but nothing seemed to help. She stated, "I never feel better, or have more energy, or sleep better or have less pain. Medication doesn't seem to [a]ffect me at all." (R. 122) She testified her doctors have told her there

is little they can do to provide her with relief, and she reported to her doctors that she felt hopeless and sad due to her condition. Even after she resumed seeing Dr. Pek regularly in 2001, Johnson's condition remained largely unchanged. The court does not find the gap in Johnson's medical treatment or failure to take medications impugns the credibility of her subjective pain complaints. *See Brosnahan v. Barnhart*, 336 F.3d 671, 677 (8th Cir. 2003) (when medications are ineffective, failure to take them does not discredit claimant).

The ALJ emphasized the fact that neither Johnson nor her husband "specifically testified [Johnson] was limited in her ability to sit," and he noted Johnson and her sister-in-law did not state, on written questionnaires, that Johnson was limited in her ability to sit. (R. 15) The ALJ further observed:

> On a personal pain questionnaire completed by [Johnson] on June 25, 2001, [Johnson] expressed her belief that her concentration abilities have decreased due to her experience of pain. This may be true. However, in describing the performance of daily activities at hearing and when undergoing a consultative evaluation on August 6, 2001, [Johnson] reported spending the bulk of her day reading and watching television. Again, both at hearing and in record, although acknowledging no difficulty sitting, she did relate she would stiffen up and have difficulty rising from a sitting position. When asked . . . what she read, [Johnson] related she would read articles and best-sellers, reading for no more than one-half hour at a time.

(R. 15, citations omitted)

The Record does not support these findings. With regard to Johnson's testimony, her attorney asked her, "How long can you sit and watch television, without having to get up?" and Johnson responded, "I try to get up every half hour, 45 minutes[;] otherwise I stiffen up so bad." (R. 42-43) On her Personal Pain/Fatigue Questionnaire, Johnson noted, "I am always tired. If I do anything – even sitting - standing - walking - talking[,] I am more tired and feel more pain." (R. 117, question 2) In response to the question,

"Does your pain/fatigue limit your ability to walk and stand or sit," Johnson replied, "Yes," and explained, "I can stand and sit for 10 mins. but need to shift position. . . . If I sit[,] I stiffen and have trouble getting up." (R. 120, question 18)

The Daily Activities Questionnaire completed by Johnson's sister-in-law, Kathy Johnson, does not even ask about the claimant's ability to sit for long periods of time. According to Kathy, Johnson is in constant pain, she rarely performs any household duties at all, and although she bathes or showers regularly, she seldom dresses, shaves, or fixes her hair. (R. 126) She noted Johnson "[c]an't go out of [the] house for any length of time" and can "sit or stand for only short periods of time." (R. 127) She stated Johnson rarely engages in social activities, only visiting family and friends on special occasions or holidays, and she has observed changes in Johnson's behavior and moods due to constant pain and lack of sleep, stating Johnson has become more weak and depressed. In Kathy's opinion, Johnson's pain "has become more severe throughout her whole body," and she "[a]ppears very tired" and has an "exhausted look" on her face. (R. 128)

The ALJ further stated Johnson "acknowledged on the reconsideration disability report that she was not limited in regard to her ability to sit." (*Id.*) Again, the ALJ appears to be placing his own misinterpretation on Johnson's response to questioning. On the Reconsideration Disability Report, Johnson replied to the question, "Describe any physical or mental limitations you have as a result of your condition since you filed your claim," as follows: "My physical and mental limitations are as hindering as they were when filing, whether sitting or standing. Yes, I can sit – but I'm still in pain – it doesn't leave. It doesn't matter what you are doing – the pain is always there." (R. 129, question 2)

Based on his determination that Johnson's subjective complaints were not credible, his reliance on the opinions of the consulting physicians, and his finding, based on a

misinterpretation of the evidence, that Johnson has no difficulty sitting for extended periods of time, the ALJ found Johnson to have "the functional capacity to perform work activity at the sedentary exertional level," except she would be limited to standing or walking for less than two hours in an eight-hour workday, and she could only perform postural activities on an occasional basis. In addition, he found she would have to avoid temperature and humidity extremes, and she could not work at heights or around dangerous machinery. (R. 20; R. 22, ¶ 5) He found that although Johnson would be unable to return to her past work as a mail carrier, she could perform jobs as a night auditor, jewelry assembler, surveillance monitor, and electronics assembler, all of which exist in sufficient numbers in the regional economy. (R. 20; R. 22, ¶ 12)

The Record contradicts these conclusions. According to Johnson's treating physician, Dr. Pek -- whose opinion was disregarded by the ALJ and the consulting physicians -- Johnson would be unable to sustain any full-time or part-time work. The ALJ rejected Dr. Pek's opinion because the doctor relied on Johnson's subjective complaints, which the ALJ found not to be credible, and based on the consulting physicians' view that no objective medical evidence exists to support Dr. Pek's opinion. However, as Johnson points out clearly in her brief (*see* Doc. No. 9, pp. 12-14), the presence of pain in eleven of eighteen trigger point sites on digital palpation represents objective evidence of fibromyalgia. *See Brosnahan*, 336 F.3d at 678 ("objective medical evidence of fibromyalgia [includes] consistent trigger-point findings"). In addition, the ALJ found Johnson to have a medically-determinable, severe impairment of fibromyalgia, which *a fortiori* includes a finding that the objective medical evidence supported his conclusion.

It appears the ALJ would require some objective medical test, like a blood test or X-ray, that would confirm a diagnosis of fibromyalgia. Yet even the courts have observed that fibromyalgia is "a common, but elusive and mysterious, disease, much like chronic

fatigue syndrome, . . . Its cause or causes are unknown, there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective." *Sarchet v. Chater*, 78 F.3d 305, 306 (7th Cir. 1996). The Eighth Circuit has held, "in the context of a fibromyalgia case, that [even] the ability to engage in activities such as cooking, cleaning, and hobbies, does not constitute substantial evidence of the ability to engage in substantial gainful activity." *Brosnahan*, 336 F.3d at 677 (citing *Kelley v. Callahan*, 133 F.3d 583, 535-89 (8th Cir. 1998)). In the present case, Johnson is unable even to engage in cooking, cleaning, and hobbies.

On this Record, the court finds ample evidence that Johnson suffers from fibromyalgia and chronic fatigue syndrome, and that her subjective complaints are credible. When considering her condition in light of the limitations she describes, both her doctor and the VE conclude Johnson is wholly unable to work. The court therefore finds Johnson is disabled and the Commissioner's decision should be reversed.

IV. CONCLUSION

For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections[4] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that the Commissioner's decision be

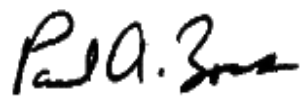
[4]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

reversed, judgment be entered for the plaintiff, and this matter be remanded for a calculation and award of benefits.[5]

The court also, therefore, recommends Johnson's motion for sentence six remand be denied.

IT IS SO ORDERED.

DATED this5th day of December, 2003.



PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

[5]**NOTE TO PLAINTIFF'S COUNSEL:** If final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.